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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Hobart Hong Lee, M.D.** **25455 Barton Road, #209B** **Loma Linda, CA 91730** **Physician's and Surgeon's Certificate No. A 112663,** Respondent.	Case No. 800-2017-035808 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 2, 2010, the Medical Board issued Physician's and Surgeon's Certificate No. A 112663 to Hobart Hong Lee, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2220 of the Code states:

"Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . ."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

". . ."

6. Section 2234 of the Code states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

". . .

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . ."

7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. A 112663 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged hereinafter:[1]

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[1] References to "Patient A" herein are used to protect patient privacy.

9. On or about April 20, 2011, Patient A commenced treatment with Respondent for his primary care needs. Between on or about April 20, 2011, and March 12, 2012, Patient A continued to be under the care and treatment of Respondent. On or about March 12, 2012, Patient A's medication regimen included, *inter alia*, Norco (hydrocodone acetaminophen) 10mg/325mg three times a day,[2] morphine extended release 30mg once a day at bedtime,[3] and diazepam 10mg three times a day.[4,5]

10. On or about March 30, 2012, Respondent saw Patient A for a follow-up visit regarding Patient A's diabetes. Patient A's medical history included chronic pain, anxiety, depression, obstructive sleep apnea, and prostate cancer, among other conditions. Patient A's medications included Norco 10mg/325mg three times a day, morphine extended release 30mg once a day at bedtime, and diazepam 10mg three times a day. During this visit, Patient A reported current acute pain, however, no additional information about the pain was noted.

11. On or about April 19, 2012, Respondent saw Patient A to follow up on Patient A's chronic pain. During this visit, Patient A reported current acute pain, which was located at the right side of his mouth. Patient A's medications included Percocet (oxycodone acetaminophen) 10mg/325mg three times a day,[6] morphine extended release 30mg once a day at bedtime, and diazepam 10mg three times a day. Respondent assessed Patient A's chronic use of opioid medications utilizing a form entitled, "Controlled Medications Management Tool: Opioids."

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[2] Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Diazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Any medical care or treatment rendered by Respondent more than seven years prior to the filing of the instant Accusation is described for informational purposes only and not pleaded as a basis for disciplinary action.

[6] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

According to the completed form, the purpose of the visit was to "address [Patient A's] chronic use of opioid medications (more than 3 months) for non-cancer pain." (Emphasis in original.) The reason for Patient A's use of opioid medications was "[l]ow back pain" and the length of use was "years." Respondent listed morphine 30mg daily as Patient A's maintenance medication and Norco 10mg/325mg as his breakthrough medication. Among the "4 As" assessed by Respondent,[7] Respondent noted that Patient A's current pain level was "9" and that he was not working, but was able to maintain self-hygiene, dress himself, and had adequate sleep. He also noted that Patient A exhibited aberrant behavior, specifically "[f]requent request for early refills" due to dental problems and that he "took more medicine than directed." Respondent adjusted Patient A's chronic pain medication regimen by changing Norco 10mg to Percocet 10mg "for additional pain control." Respondent also noted that Patient A could not take morphine during the day "due to sedation."

12. On or about May 14, 2012, Respondent saw Patient A for a follow-up visit. During this visit, Patient A reported current acute pain, this time in his lower back. Patient A's medications included Percocet 10mg/325mg three times a day, morphine extended release 30mg once a day at bedtime, and diazepam 10mg three times a day. Respondent performed another assessment of Patient A's chronic use of opioid medications utilizing the "Controlled Medications Management Tool: Opioids" form. According to the completed form, the reason for Patient A's use of opioid medications was "[l]ow back pain" and Respondent identified morphine 30mg daily as Patient A's maintenance medication, Percocet 10mg/325mg three times a day as his breakthrough medication, and Valium three times a day as an adjunctive pain medication. Respondent noted that Patient A's current pain level was "3" and that he could not work, but was able to maintain self-hygiene, dress himself, and had adequate sleep. Respondent also noted that Patient A experienced headache as an adverse effect of the pain medications.

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[7] The "4 As" referred to Analgesia, Activities of Daily Living, Adverse Effects, and Aberrant Behavior.

13. On or about June 13, 2012, Respondent saw Patient A to follow up on Patient A's chronic pain and diabetes. Patient A's medications included Percocet 10mg/325mg three times a day, morphine extended release 30mg once a day at bedtime, and diazepam 10mg three times a day.

14. On or about July 11, 2012, Patient A was scheduled to see Respondent, however, Patient A called Respondent's office and cancelled the appointment due to significant pain that he was experiencing. On or about July 20, 2012, Patient A reported to Respondent's office that he quit taking his hypertension and anti-depression medications due to his financial situation.

15. On or about July 30 2012, Respondent saw Patient A for a follow-up visit to refill his medications and discuss laboratory results. Patient A's medications included Percocet 10mg/325mg three times a day and diazepam 10mg three times a day. However, Respondent changed his prescription for morphine extended release 30mg from once a day at bedtime to two times a day. During the visit, Respondent assessed Patient A's chronic use of opioid medications. Respondent noted that Patient A was experiencing pain from dental infections. Respondent also noted that Patient A was unable to buy food and stopped taking his anti-depression medications due to lack of money.

16. On or about September 28, 2012, Respondent saw Patient A to refill his medications and follow up on Patient A's chronic pain and assess his chronic use of opioid medications. Patient A's medications included Percocet 10mg/325mg three times a day and diazepam 10mg three times a day. However, Respondent changed his prescription for morphine extended release 30mg once again from two times a day to three times a day. As part of his chronic opioid use assessment, Respondent noted that Patient A's current pain level was "3" and that he could not work, but was able to maintain self-hygiene, dress himself, and had adequate sleep.

17. On or about December 5, 2012, Respondent saw Patient A to refill his medications. Patient A reported that he stopped taking his hypertension medications because he could not afford them. Patient A's medications included Percocet 10mg/325mg three times a day, morphine extended release 30mg three times a day, and diazepam 10mg three times a day.

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18. On or about January 4, 2013, Respondent saw Patient A for a follow-up visit regarding Patient A's diabetes. Patient A's medications included Percocet 10mg/325mg three times a day, morphine extended release 30mg three times a day, and diazepam 10mg three times a day. Patient A reported to Respondent that he had stopped taking his diabetes medications and began eating poorly due to his financial difficulties.

19. On or about February 8, 2013, Respondent saw Patient A for a follow-up visit to refill his medications. Patient A reported that his depression was not improving due to his financial situation. Patient A's medications included Percocet 10mg/325mg three times a day, morphine extended release 30mg three times a day, and diazepam 10mg three times a day. During this visit, Respondent referred Patient A for a sleep medicine consultation relating to his sleep apnea due to continuing complaints of trouble sleeping.

20. On or about March 13, 2013, Respondent saw Patient A for the last time. The purpose of the visit was to refill Patient A's medications. Patient A's medications included Percocet 10mg/325mg three times a day, morphine extended release 30mg three times a day, and diazepam 10mg three times a day.

21. On or about April 17, 2013, Patient A passed away. The reported cause of death was acute morphine toxicity by suicide.

22. Between on or about March 30, 2012, and March 13, 2013, Respondent noted that the reason for Patient A's chronic use of opioid medications was back pain, however, Respondent did not adequately document a history of Patient A's back pain, including, *inter alia*, when the pain began, what precipitated the pain, the location of the pain, the severity of the pain, the nature of the pain, whether the pain radiated to other parts of the body, what made the pain better or worse, previous evaluations such as imaging or laboratory studies, and previous treatments that had been tried.

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23. Between on or about March 30, 2012, and March 13, 2013, Respondent did not document a musculoskeletal examination of Patient A in order to evaluate his chronic pain, to justify the prescribing of opioid medications for the pain, including the escalation in morphine doses, and to evaluate the possibility that Patient A's prostate cancer had spread and was the cause of the chronic pain.

24. Between on or about March 30, 2012, and March 13, 2013, despite Patient A's history of prostate cancer, Respondent did not order any x-rays or other imaging of Patient A's back or any prostate specific antigen (PSA) testing to evaluate for possible underlying causes of his chronic pain, nor did Respondent reference any prior imaging or PSA testing that had been done.

25. Between on or about March 30, 2012, and March 13, 2013, Respondent prescribed opioid pain medications to Patient A without an appropriate history, physical examination, and workup of Patient A's chronic pain, and he changed Patient A's opioid pain medications from Norco to Percocet and increased Patient A's doses of morphine without documenting a rationale or justification for making those changes.

26. Between on or about March 30, 2012, and March 13, 2013, despite Patient A's history of sleep apnea, Respondent prescribed opioid and benzodiazepine medications to Patient A without documenting any evaluation or assessment of Patient A's sleep apnea condition and without documenting any discussion with Patient A of the risks of these medications for patients with sleep apnea, including respiratory depression and death.

27. Between on or about March 30, 2012, and March 13, 2013, despite Patient A's depression and anxiety, Respondent did not document that he assessed Patient A for suicidal thoughts or intent.

28. Respondent committed repeated negligent acts in his care and treatment of Patient A, which included, but was not limited to the following:

(a) Respondent failed to document an adequate history in his ongoing management of Patient A's chronic pain;

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(b) Respondent failed to document a physical examination relating to Patient A's chronic pain and supporting the need for prescribing controlled pain medications and escalating the doses of those medications;

(c) Respondent failed to adequately evaluate Patient A's back pain despite Patient A's history of prostate cancer;

(d) Respondent prescribed opioid pain medications to Patient A without an appropriate history, physical examination, and workup of Patient A's chronic pain, and he made changes to the type and doses of controlled pain medications prescribed to Patient A without documenting the rationale, justification, or medical need for the changes;

(e) Respondent prescribed sedating medications to Patient A despite Patient A's history of sleep apnea and without documenting any discussion with Patient A of the risks of respiratory depression and death; and

(f) Respondent failed to adequately evaluate suicidal thoughts or intent despite Patient A's depression and anxiety, and he failed to document any such evaluation or assessment.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

29. Respondent has subjected his Physician's and Surgeon's Certificate No. A 112663 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment of Patient A, as more particularly alleged in paragraphs 9 through 28, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 112663, issued to Respondent Hobart Hong Lee, M.D.;

2. Revoking, suspending or denying approval of Respondent Hobart Hong Lee, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Hobart Hong Lee, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: March 13, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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